TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-16-0189-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider has outlined key components regarding patient's visit with him. Dr. Lopez has attached dictation regarding patient's visit with him."

Amount in Dispute: $255.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2014	99204	$255.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes that contained a narrative description:
   - 29 – The time limit for filing has expired
   - W3 – Request for reconsideration

- 150 – Payer deems the information submitted does not support this level of service

Findings

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

(1) The carrier denied codes 99204 with denial code 29 – "The time limit for filing has expired" this denial was not maintained as on reconsideration a denial code of 150 - "Payer deems the information submitted does not support this level of service" was used as the denial code. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;"

The Centers for Medicare and Medicaid Services guidelines as it relates to documentation requirements of Evaluation and Management Codes can be found at; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

Submitted code 99204, date of service October 28, 2014 is described as: Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

Comprehensive

- Documentation of the Comprehensive History
  - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed one element of a chronic condition, thus not meeting this component.
  - Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least ten organ systems must be reviewed. Documentation found listed one system, this component was not met.
  - Past Family, and/or Social History (PFSH) require a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed one area, (Past history). This component was not met.
- Documentation of a Comprehensive Examination:
  - Requires at least nine organ systems to be documented, with at least two elements listed per system. The documentation found listed one body areas/ one organ system: (Each extremity, and Musculoskeletal). This component was not met.
- Medical Decision complexity was found to be low
- Insufficient information found to support time spent with patient

Pursuant to Rule 134.203(b) no separate payment can be recommended.

2. The submitted note from October 28, 2014 was reviewed however, the documentation requirements to support the level of evaluation and management was not supported. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 21, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.